23/06/2026

Transition Care Program Review
Contributions and Accommodation Reform Branch,
Department of Health, Disability and Ageing
Via email TCPReview@health.gov.au

Dear Adj Prof Debora Picone,

Transition Care Program Review

Thank you for the opportunity to provide feedback to the Transition Care Program Review.

Ageing Australia is the national peak body representing providers across the aged care sector, including retirement living, seniors housing, residential care, home care, community care and related services.

We welcome the Government's review of the Transition Care Program (TCP, or the Program), finding it particularly timely in light of recent reforms to strengthen the sustainability, coordination and effectiveness of services across the aged care system.

For more than two decades, the TCP has played a critical role in supporting older Australians to transition from hospital care to community-based supports, providing a vital bridge between the health and aged care systems. Throughout this time, the Program has enabled older people to receive care that is responsive not only to their clinical needs, but also to their individual goals, preferences and circumstances.

However, the Program has not evolved to meet the needs of the people in it or the providers of care. As is the case across the aged care system, the TCP is now providing care for an older cohort, often with more complex care needs.

In many parts of the country, the Program has been running at capacity for years, limiting time for proper discharge planning and care transitions. As a result, we have seen reports of increased hospital readmissions during and after TCP placements, and high rates of unpaid overtime by care workers to facilitate transitions out of the program.

While the review appropriately focuses on whether the Program remains participant-centred, has clear objectives, effective delivery models, and measurable outcomes, it is also important to consider the TCP within the broader health and aged care ecosystem. Its effectiveness is inherently influenced by the policies, funding arrangements and service pathways that surround it. Consideration must therefore be given to how the Program both affects, and is affected by, concurrent reforms across the continuum of care.

Without a system-wide perspective, there is a risk that existing fragmentation between health and aged care services is reinforced rather than addressed, undermining efforts to deliver coordinated and efficient care.

The TCP has great potential to ease the burden on public hospitals and improve the transition into formal aged care, but this will require greater support and flexibility for TCP providers. Strengthening the TCP should therefore be viewed not only as an opportunity to improve a single program, but also as a means of supporting greater integration across the broader care system.

In this context, we present the following feedback, informed by consultation with our members, to support the ongoing development and future sustainability of the Transition Care Program.

Summary of Recommendations

R1: Increase the TCP subsidy to a level that reflects contemporary care costs and participant acuity, with alignment to equivalent AN-ACC classifications as a minimum benchmark to ensure safe, high-quality and sustainable service delivery.

R2: Expand Program capacity, ensuring it remains focused on transitional and restorative care outcomes, by:

- Increasing the number of national places by 10 per cent,
- Making existing temporary places permanent, and
- Establishing an ongoing growth mechanism to increase places in response to Program demand.

R3: Establish a nationally consistent mechanism for publishing and maintaining clear information on Transition Care Program service models, eligibility criteria and service offerings across jurisdictions, to support consistency in program interpretation, reduce unwarranted variation, and enable identification and scaling of effective practice.

R4: Improve system-level visibility of aged care service availability, including residential aged care bed capacity and Support at Home package availability, to support timely discharge planning, continuity of care and effective system-wide demand management.

R5: Extend the standard Transition Care Program duration from 12 weeks to up to 16 weeks, with flexibility based on clinical need and consideration of service availability, to better support safe discharge planning in the context of broader aged care system capacity constraints.

R6: Strengthen national guidance on the purpose and intended outcomes of the Transition Care Program to enable greater flexibility and support innovation in transitional care models, while maintaining its role as a time-limited restorative service.

R7: Strengthen transitions between systems through earlier engagement in the admission and discharge journeys, such as a pre-acceptance assessment and an occupational therapy assessment prior to transfer, to ensure care goals are realistic, participant-centred and reflect capacity of the discharge environment.

R8: Improve coordination of care by standardising discharge information requirements to ensure the timely provision of essential clinical and functional documentation to receiving providers, including current medication regimens, behavioural and cognitive assessments, functional status and clinical care needs.

R9: Strengthen TCP governance by embedding principles from existing collaborative models of care into Program design to establish institutionalised coordination as a minimum service standard across the interface, informed by an evaluation of legislative and regulatory differences affecting accountability, decision-making and information-sharing at transitions.

Funding must reflect an ageing population with increasing acuity of needs

The Transition Care Program operates in an environment of increasing demand, rising participant complexity and growing pressure across both the health and aged care systems. Australia's population is ageing, with the proportion of those aged 65+ increasing from 12.9% in 2005, to approximately 17.0% of the total population in 2025[i]. At the same time, one in five Australians now lives with two or more chronic conditions[ii].

These broader demographic and epidemiological shifts are increasingly being reflected in the profile of TCP participants, with more people entering the Program with higher levels of frailty, multi-morbidity and functional decline. Yet current funding settings for the Program have not adjusted in line with these changes in service demand and care acuity. For example, providers reported that, although they have a core role in the Program, funding arrangements do not meet the full cost of allied health supports like speech pathology, dietetics or occupational therapy.

The existing TCP subsidy of $262.62 per bed per day (PBPD)[iii] is significantly lower than the average Australian National Aged Care Classification (AN-ACC) subsidy of approximately $316 PBPD[iv]. This differential creates structural pressure on service viability and raises concerns among residential aged care providers in particular about their capacity to deliver optimal, person-centred care within current Program settings.

Despite this, providers continue to express their support for the Program and interest in expanding their TCP offerings further to help meet growing demand. Without complementary investment in Program funding, however, any increases in the number of TCP places would constrain provider capacity to deliver safe, timely and person-centred care given rising cost of complex care delivery.

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R2: Expand Program capacity, ensuring it remains focused on transitional and restorative care outcomes, by:

- Increasing the number of national places by 10 per cent,
- Making existing temporary places permanent, and
- Establishing an ongoing growth mechanism to increase places in response to Program demand.

Transparency of program operation can strengthen consistency in service delivery and support systems planning

Effective care transitions rely on clear service pathways and a shared understanding of the role that different programs play across the health and aged care systems. Without this, there is a risk that services may unnecessarily vary and programs duplicate rather than complement one another. While the 2019 Review of the Transition Care Program identified concerns regarding variation in program delivery and implementation[v], less attention was given to the potential for overlap between TCP and adjacent services.

We have already received examples highlighting similarities between the TCP and the Support at Home Restorative Pathway. Similarly, misunderstanding of Program operation has contributed to an increasing number of clinically inappropriate referrals to the TCP, such as participants with palliative care needs and long-stay older hospital patients with limited restorative needs. It should be acknowledged that a confounding of the purpose of the TCP is not an isolated consequence of limited program transparency, but rather,

an outcome of system capacity constraints and how pressure distorts meaningful patient flow.

However, these insights highlight the importance of a shared understanding of service roles and functions across the health and aged care systems. As new models of care emerge, greater transparency regarding Program design and service offerings will help establish a clearer and more coherent system architecture, ensuring services remain distinct, complementary and responsive to the needs of older Australians. This, in turn, will support more appropriate care allocation and decision-making, strengthen system-level planning, reduce duplication, and facilitate more coordinated care pathways.

The criticality of service transparency extends beyond the scope of the TCP. Limited visibility of aged care service availability, including residential aged care places and Support at Home services, can delay transitions to longer-term care arrangements and contribute to extended TCP stays or avoidable hospital readmissions. Though such action falls outside the scope of this review, it should be noted that improved coordination and sharing of information across programs would support more effective care transitions and continuity of care.

Importantly, this is not a call for additional reporting obligations on providers or hospital and health services. Rather, it reflects the role of government as system steward in ensuring relevant information is appropriately collected, integrated and shared to support coordinated planning, efficient service delivery and improved outcomes for older Australians.

R3: Establish a nationally consistent mechanism for publishing and maintaining clear information on Transition Care Program service models, eligibility criteria and service offerings across jurisdictions, to support consistency in program interpretation, reduce unwarranted variation, and enable identification and scaling of effective practice.

R4: Improve system-level visibility of aged care service availability, including residential aged care bed capacity and Support at Home package availability, to support timely discharge planning, continuity of care and effective system-wide demand management.

Flexibility in the Program is essential to supporting the broader aged care sector

The Transition Care Program was established more than twenty years ago and has remained largely unchanged despite significant reform across both the health and aged care sectors. While the Program's core objective remains highly relevant, there is an opportunity to review whether current program settings continue to align with the needs of participants and the broader operating environment.

Greater flexibility within the Program would support a more individualised approach to care and recovery, and ensure that services continue to complement, rather than substitute, longer-term aged care programs. The TCP should not become a holding mechanism for individuals awaiting access to other supports. However, where delays occur in accessing ongoing care, program settings should be sufficiently responsive to support continuity of care and reduce the risk of adverse outcomes associated with premature discharge.

Importantly, increased flexibility would create opportunities for innovation in service delivery and enable the Program to adapt to changing patterns of care need. As the aged care system continues to evolve, modernising elements of the Program's design will help

ensure it remains responsive, effective and capable of delivering on its intended objectives.

Strengthening flexibility within the TCP should therefore be viewed as an opportunity to enhance participant outcomes while ensuring the Program remains fit for purpose in a contemporary health and aged care system.

R5: Extend the standard Transition Care Program duration from 12 weeks to up to 16 weeks, with flexibility based on clinical need and consideration of service availability, to better support safe discharge planning in the context of broader aged care system capacity constraints.

R6: Strengthen national guidance on the purpose and intended outcomes of the Transition Care Program to enable greater flexibility and support innovation in transitional care models, while maintaining its role as a time-limited restorative service.

Communication, responsibility, and accountability must be strengthened at the health-aged care interface

As a program operating across the health-aged care interface, the success of the TCP is dependent on clear communication, well-defined responsibilities and strong accountability at each stage of the participant journey.

Timely and comprehensive transfer of information is essential to ensuring providers can safely assume responsibility for a participant's care and deliver services that align with their clinical needs, goals and preferences. Where information is incomplete, delayed or inconsistent, there is an increased risk of fragmented care, duplication of effort and poorer participant outcomes. For example, providers noted that participants are often discharged from hospital with new or changed medication regimens. Entry into the TCP is an ideal opportunity to for a formal medication review from an accredited pharmacist, and more generally, to strengthen discharge processes and align expectations regarding information sharing for greater continuity of care and more effective delivery of the Program.

Such processes must be underpinned by strong governance structures and policy procedures that acknowledge the complexity in sharing responsibility at and across the interface. This Review provides an opportunity to embed models of care that provide dedicated coordination functions and clear points of contact, such as Western Australia's Aged Care Hub[vi], into the program structure of the TCP to shift from what is often relationship-based action to a foundation of systematised collaboration.

Consideration should therefore be given to how differences in legislative and regulatory frameworks affect decision-making and accountability when care transfers between systems. Variations in requirements relating to clinical governance, restrictive practices and reporting obligations can create uncertainty regarding responsibilities at key transition points, potentially impacting the timeliness and quality of care provided.

R7: Strengthen transitions between systems through earlier engagement in the admission and discharge journeys, such as a pre-acceptance assessment and an occupational therapy assessment prior to transfer, to ensure care goals are realistic, participant-centred and reflect capacity of the discharge environment.

R8: Improve coordination of care by standardising discharge information requirements to ensure the timely provision of essential clinical and functional documentation to receiving providers, including current medication regimens, behavioural and cognitive assessments, functional status and clinical care needs.

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Conclusion

The Transition Care Program remains a vital component of Australia's health and aged care system, providing an essential bridge for older Australians moving from hospital to community-based care. However, the context in which the Program operates has changed significantly since its establishment, with rising demand, increasing participant complexity, and ongoing pressures across both the health and aged care systems.

This review presents an important opportunity to ensure the Program is appropriately resourced, clearly defined, and better integrated within the broader care system. Strengthening funding settings, improving transparency, enhancing flexibility, and clarifying roles at the health–aged care interface will be critical to maintaining the Program's effectiveness and sustainability into the future.

Ageing Australia encourages reforms that support consistency across jurisdictions while preserving the ability of the Program to respond to individual needs and local system conditions. With the right settings in place, the Transition Care Program can continue to deliver high-quality, restorative care and play a strengthened role in enabling safe, timely and coordinated care transitions for older Australians.

Yours sincerely,

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[i] *Older Australians*. Australian Institute of Health and Welfare, Australian Government; 2024. Accessed June 17, 2026. Older Australians, Demographic profile - Australian Institute of Health and Welfare

[ii] *The ongoing challenge of chronic conditions in Australia*. Australian Institute of Health and Welfare, Australian Government; 2024. Accessed June 17, 2026. Australia's health 2024: data insights: The ongoing challenge of chronic conditions in Australia - Australian Institute of Health and Welfare

[iii] *Schedule of Subsidies and Supplements for Residential and Transition Care*. Department of Health, Disability and Ageing, Australian Government; 2026. Accessed June 18, 2026. Schedule of Subsidies and Supplements for Residential and Transition Care | Australian Government Department of Health, Disability and Ageing

[iv] *Residential aged care funding updates*. Department of Health, Disability and Ageing, Australian Government; 2025. Accessed June 18, 2026. Residential aged care funding updates | Australian Government Department of Health, Disability and Ageing

[v] *Review of the Transition Care Programme – Final Report*. KPMG; 2019. Accessed June 15, 2026. Review of the Transition Care Programme – Final Report | Australian Government Department of Health, Disability and Ageing

[vi] *Aged Care Hub*. Government of Western Australia, Department of Health; 2024. Accessed June 19, 2026. Aged Care Hub